

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Sources of financial data on Medicare providers --
mandated reports

-- IRS form 990

-- Nancy Kane, Harvard School of Public Health

MR. HACKBARTH: I'm sure Craig is going to introduce not just the topic but the speaker, as well. but Nancy, welcome. Nancy and I knew each other a little bit in Boston and had a few occasions to talk. So it's good to have you with us.

MR. LISK: I'd like to introduce you to Nancy Kane, Professor of Management in the Department of Health Policy and Management at the Harvard School of Public Health.

Dr. Kane's research is focused on financial and managerial performance of health care organizations.

Today she is going to discuss her work on IRS form 990 as a data source for reporting on hospital investments, endowments and access to capital. This is one of two reports mandated by the MMA that are due June 1st of this year which the Commission will be discussing this morning.

After you're through with the discussion of the 990 project with Dr. Kane, David, Jeff and I will discuss the other Congressional mandated report on the need for and sources of current data to determine the solvency and financial circumstances of Medicare providers.

* DR. KANE: Thank you, Craig. Thank you Commissioners and Mr. Hackbarth.

It's a pleasure to be here this morning to talk about a subject that I probably know a lot about it and you probably don't want to know too much about. So I will try to keep it brief brief. But I guess Congress is interested in monitoring the financial health of hospitals and understanding the impact of not just Medicare but other forces on the hospitals' financial condition, and obviously is looking to the 990s as one of the major sources of information.

So what I'm going to try to do today is give you some idea of how valuable and not so valuable at times the 990s are as a source of information on these fairly critical issues, and I think becoming increasingly challenging to understand.

Just keep in mind, the 990s' purpose is an informational document required by the IRS and it's used by the IRS and some state oversight agencies like the attorney

generals in charge of charitable assets in a state. It's used by donors. It's often read by the media more than anybody else. In fact, that's where a lot of the attention is paid to charitable organizations. It's often the journalists trying to learn how to read these things. I have given many sessions, in fact, teaching journalists how to read these things.

But their main purpose is to decide whether the organization continues to meet requirements for tax exemption and that's quite a different purpose than trying to ascertain financial stability. Many of these organizations are small and oriented towards non-health-related activities. So again, a very different focus than what you might want to know about in a hospital. And that's where some of the issues come up when you try to do financial analysis. And I will be explaining those in more detail in a few minutes.

The good news about the 990s is the public disclosure has expanded a lot in recent years, since around '96 when the IRS began to require that charities put their 990s in a public domain and the GuideStar web site came into being and therefore people have access to them without having to go to the organization and stand there and beg for the form 990, which I used to have to do.

Who reports? All tax-exempt organizations with greater than \$25,000 in gross receipts, excluding churches. Hospitals that are religiously affiliated do report so they're not exempt. But this means more than 220,000 public charities and 60,000 private charities file some version of the IRS form 990. It's a lot of organizations, a lot more than the IRS can possibly audit or even review in any one year.

The types of information included on the 990s, it's a six-page form plus up to 40 or 50 pages of attachments. There are 105 items that are specified and requested in the forms, and there's 45 pages of instructions. So it's a lot of data around the revenue expenses. That would be sort of like an income statement, functional expenses. Again because of charitable purpose there's a real interest in the division of expenses between what the charity program is comparing to the management expenses and the fundraising expenses.

There is a disclosure of program service accomplishments. There's sort of a balance sheet. I'm saying sort of because my standard, by the way, is the audited financial statements that are governed by generally accepted accounting principles. So when I sort of devalue a little bit the 990, it's because it doesn't quite come up to the generally accepted accounting principles version or the

audited financial statements.

It also discloses compensation because of the charitable issues involved with inurement that the IRS and others are interested in. And one of the most valuable things the 990 does is it lists all of the affiliates and subsidiaries of the entity that's reporting. We'll come back to that, though because that actually makes it hard in other ways to understand the financial condition of the hospital.

That's sort of an overview of the 990s. Now I'm going to get into the specific question of how valuable is the 990 as a data source for reporting on investments and endowments. One of the first things you might want to know is how well do they report information you need to know about investments and endowments? Under generally accepted accounting principles, investments are broken up into these various categories that are used differently depending on where they're coming from. So there's restricted and unrestricted is the first category, where unrestricted is available for general operating purposes. Restricted it is restricted by donors.

The management of a hospital cannot use donor restricted investments for any purpose other than the donor specified purpose. So those assets are not available to meet an operating deficit or repay debt or any of the general operating purposes of the organization.

Their unrestricted assets are broken up into operating cash, board-designated investments which are amounts of securities that the board has said should be used, usually for capital purposes. They can also undesignate them, so they are considered available for general operating purposes.

And then a third category is trustee-held investments which are investments set aside under some sort of contractual arrangements such as debt service funds or self-insurance funds.

Only the top two categories of unrestricted funds, operating cash and board-designated cash, are commonly used to create ratios that creditors would look at for the availability of cash or days cash on hand as part of assessing hospitals' financial health. So you do need to be able to segregate out these categories to do an effective analysis of hospitals' liquidity and days cash on hand.

The bad news is in the 990 none of these categories are recognized. All investments are reported on one line item on the balance sheet. So sometimes it's disclosed in the attachments but the attachments, as I say, do take a little more time and are rarely collected in any kind of automated form.

Another issue around investments, and one reason you might be interested in investments is that they generate income. And the income generally comes in three different classifications. If you look across the top of my slide, the top row, there's dividends and interest income, there's realized gains and losses which is basically what you realize when you sell the asset for above or below cost. And then there's unrealized gains and losses which is the fluctuations in market value of investments that you continue to hold.

Under generally accepted accounting principles investment income hits the income statement or not depending on which type of investment it comes from. So if it's an unrestricted investment it hits the income statement unless it's unrealized gain and loss, in which case it does not hit the income statement.

DR. ROWE: I'd like to ask a clarification, because I just remember things as being a little different than the way you stated them, Nancy. so maybe you can clarify this for me.

I was under the impression that for a restricted gift of an endowment that, perhaps depending upon the language of the deed of gift, capital gains on the corpus can in fact be used for unrestricted purposes. And therefore, would appropriately be included by rating agencies and others when they're looking at the financial stability of an organization.

DR. KANE: Depending on how detailed you want me to get. You're absolutely right, some donors do stipulate that their endowment is to be set aside in perpetuity. But some of the return may be used for general purposes.

But it's not all.

DR. ROWE: Some organization that gets to be most of the --

DR. KANE: That's correct.

DR. ROWE: So in a restricted category --

DR. KANE: Unfortunately, that's the general notion. There are states that allow hospitals to keep all of that in a restricted account and have all of the income accrue to a restricted net assets until management chooses to use it. So it will go back and forth. You have to be able to read the footnotes, let me put it this way, to know when the restricted asset income can be moved into unrestricted.

So in general, and I'm really trying to keep it general, depending on where the investment income is coming from it either hits the income statement or it doesn't. If it doesn't, it hits the change in equity, change in net assets. And that's an important distinction in terms of

determining, for instance, your excess revenue or your bottom line.

Unfortunately, the 990 doesn't keep that distinction clear. So there are many times when the 990 is looking at income that should have just been a change in net worth or net equity in the donor-restricted assets that it classifies as income that goes into what you would call your income statement.

And that's one of the biggest problems with the 990. If you want to know the bottom line, you've got a mixture of restricted and unrestricted revenues in there, and you need to know exactly which ones should go on the bottom line.

I've compared these to audits and it's often off. In fact, I'll give you an example of that.

MR. HACKBARTH: Thanks, Jack, for the question.

Just one reminder before Nancy proceeds. Because of the statutory deadline for this report, which is June 1 of this year, this is going to be the only time that we discuss these matters. So it's even more important than usual that if you have questions or you have concerns, this is going to be your opportunity to get them clarified in we're fortunate to have Nancy here to help us do that.

DR. KANE: So I won't be counted against going over my time?

I think just to show you how important investment income is and understanding where it's coming from and how much it is, this is a charge of a state that I generated from their audited financial statements, not the 990s. And what this shows you is the excess revenue for all the hospitals in this state for the period '98 through 2002 from their audited financials.

What I want you to notice is how much of a difference investment income makes in the level of excess revenue, which is the numerator by the way of your total margin figure, which I know you'll be talking about again in a little bit.

So one of the things you might notice from this chart is that investment income was driving the excess revenue right up through 2000. And then suddenly, you know right when the stock market doesn't do too well. 2001, 20002 investment income practically disappears.

In that sense, the total margin would make these hospitals look worse over this period. However, the green is their operating income which is the result, basically, of their patient service mission. And you see it rising over this same period.

So if you're just looking at total margin, you'll think oh, they're doing worse over this period. But if

you're concerned with how the third-party payment system is operating or how the patient care mission is doing, you get the exact opposite impression.

So again, this is just to explain how important it is to be able to pull out investment income and understand its impact on the bottom line.

I'm going to take this year 2002 --

MS. ROSENBLATT: Nancy, I'm sorry.

When you're using the term investment income, are you only counting what's coming in? Or is it net of what might be going out? Interest expense.

DR. KANE: It's before interest expense, which is actually an operating expense. There may be some other nets against it that relate to the cost of managing the investment fund but it's not counting interest expense that you use to service your debt.

Let's look at 2002 for a minute. You'll notice that investment income has practically disappeared and that other non-operating revenue is negative. I just want to give you a sense of the magnitude of what's underneath those numbers, and to help you to see why it's important to be able to pull out investment income and its various categories.

This is that 2002 of that state. And you can see that contributions are positive but investments and other entities, they're losing cumulatively about \$5 million that year. Interest and dividends generated \$31.8 million but that was almost entirely offset by realized and unrealized losses. That's basically the effect of the stock market drop in 2002. So they end up having negative non-operating revenue.

But again, if you're trying to assess the performance of an organization, it really does help to understand where the negativity is coming from. And here you can see very much it's related to the drop in market value of investments.

The next issue I wanted to talk about is capital access. And these are measures of capital access by financial stability. This is the same state that I've been showing you all along. And as of 2000 we had roughly seven years of data on these hospitals. What I've done is pull out seven of the key ratios that one would look at to determine capital access.

What I've also done is categorized these hospitals based on seven years of data as to whether they were distressed, whether they had red flags, which meant they had some bad things in their performance that you would worry about as an analyst, whether it looked like they had barely sustainable performance or whether they looked advantaged,

like they were had very strong financial performance and it gave them a competitive advantage.

This is one state. This is not, by the way, a typical state necessarily. I don't know what a typical state looks like because we don't have a national dataset that does this this way. But it gives you a sense, by categories the hospitals this way, how these seven ratios differentiate across varying degrees of financial distress. And it helps you understand why these ratios are quite useful to have if you're going to assess access to capital.

What you see, very clearly, total margin pretty much correlated with the financial stability or instability, operating margin also very much correlated. Days in accounts receivable which is, by the way, one of the ratios that you can get from the 990 pretty cleanly, does not differentiate much across these four categories in this particular state. This is really how fast are you collecting your revenue. It doesn't look like the financial instability in this state is caused by slow payment.

Days cash on hand, very closely related to financial status. Again, you can't calculate that, as I mentioned before, because of the poor categorizations on the 990 of investments.

Equity financing, which is a proportion of your total assets financed by equity, pretty much correlated and you can get that from a 990 reasonably well. It's actually close to the audited.

Debt service coverage you cannot get from the 990 but it's a key ratio used by creditors and you can see again it's highly correlated with financial status.

Average age of plant, you can get from the 990 and it does show a relationship with the financial status categories.

DR. ROWE: Nancy, I'm a little concerned if a table like this is going to appear in the MedPAC document because it indicates that MedPAC feels that an operating margin of 1 percent is sustainable, makes an institution sustainable.

These are not-for-profits, so there's no tax and presumably not many hospitals pay payments in lieu of taxes. But there are capital expenditures that are required. I just don't see 1 percent as being sustainable, maybe necessarily. We get into a lot of arguments about what the margin should be when we try to figure out what the payment adjustments should be.

If we're going to publish this, I don't want it out there for people to reference as MedPAC's definition of a sustainable hospital.

DR. KANE: That's really up to you how you want to

categorize it. I will say a 5 percent total margin does help and so does an eight-year-old plant, which is right about the national median.

DR. ROWE: But the operating margin on the slide is 1 percent. And I don't think it's sustainable. You can't sustain an institution and make any capital investments over time at 1 percent in my mind, in my experience.

DR. KANE: Well, these places have actually survived and are still doing very well in 2002.

DR. REISCHAUER: Why can't you? They have a lot of investment income and they choose to use that for good purposes.

MR. MULLER: But Nancy said, we don't know what is a representative sample, and so forth.

DR. ROWE: They don't have a lot of investment income. Most of their endowment is restricted.

DR. REISCHAUER: I'm saying they may or they may not. And I don't think we really know.

DR. ROWE: You can't tell from that, but there are hospitals, and Ralph's may or may not be one of them, that would find a 1 percent operating margin to be the only source they had of capital for IT improvements or other kinds of changes in a market that demands those kinds of changes.

It just seems like a definition that maybe it's the right definition. But I'm not sure we've discussed it here at MedPAC.

DR. NEWHOUSE: But isn't that a question of how we just labeled the columns?

DR. ROWE: Absolutely. Maybe you want to call it stable.

DR. NEWHOUSE: Should there be some indication of the range or variability within each of the columns?

DR. KANE: That's fine. I can do that.

DR. ROWE: For the purpose of this analysis, but it could be used for a different purpose. That's all.

MR. HACKBARTH: I'm not sure whether there is an intent or not to include this particular table in a MedPAC report. The way I understand it is Nancy's using this to try to illustrate to us what's available on the form and how well it correlates with different levels of financial performance. And what label you attach to them, we don't need to focus on right now.

Your point is well taken though. I hear you.

DR. KANE: Any other questions about these ratios and what they mean? And the fact that only three out of the seven are available in a reasonable way out of a 990.

I wanted to give you an example of, a comparison

actually, of a 990 versus the audited financials. And for good measure we threw in the Schedule G from the Medicare Cost Report, which you may or may not want to talk about today.

What you see here on the income statement of this very large teaching hospital is the net patient service revenue across the audit, the 990 are close. The Medicare Cost Report, for some reason, has a lower net patient service revenue. And that can be for a lot of reasons that I won't go into today, but I did write a whole article about that, if you want to read it some day.

But where the 990 has real discrepancies with the audit is under other operating revenue. And that's the problem of the mixing of restricted and unrestricted revenues where it's putting into the income statement revenues that the audits say do not belong there. They belong as a change in net assets in a restricted account.

What that does, if you scroll on down to the operating income, it throws the operating income off by about \$20 million and makes it look better in the 990 than it is in the audit.

Now some of you who are looking at the Medicare Cost Report column are probably saying wow, look how close the Medicare Cost Report is on the operating income. And that's great and once in a while that happens.

But then if you keep on going down below the operating income, here's where the Medicare Cost Report gives you trouble. It doesn't properly classify the investment income. It calls it a donation, a contribution.

And then if you get to the bottom bottom line, excess revenue over expense, the 990 continues to be off by \$20 million because it's got restricted revenues mixed in there. But the Medicare Cost Report had this other unfortunate area called other expense in which they put in capital donations and other changes to net assets that don't run through an income statement. But they ran through the income statement on the Medicare Cost Report. So you end up about \$25 million off on the Medicare Cost Report in the bottom line.

Okay, these are little numbers on a percentage basis. The audit gives you an operating margin of minus 1.4 percent and a total margin of minus .1 percent, both of which are below that state's median operating and total margin. The 990 does not look a heck of a lot better except that it raises this hospital into the top half of performers in their state. And the Medicare Cost Report, it depends on which number you want to pick, where they land relative to the state median.

So these are small numbers. People say so what,

it all comes out in the end. But actually, if you're really trying to do financial analysis and compare it to their peers or their state or national data, even these small numbers that are operating income and total margin make a difference. Therefore, it is better to have something accurate in trying to understand your bottom line, your total margin and your operating margin.

Another hospital that is much smaller shows that small classifications can make a huge impact. This is a critical access hospital. Obviously people are concerned about their operating performance and how well they're doing. They've been deemed an essential community hospital. If you look at operating income on the audit they make \$800,000. If you look at it on the 990, they lose \$39,000 as it relates to how they've classified their expenses. And they are obviously not the same classification, whatever reason. It turns out they have the same total margin but a very different operating margin.

So if you look at the operating margin under the audit it's 5.8 percent. One would conclude -- I think even maybe Dr. Rowe would conclude -- that's probably sustainable. But if you look at the 990, you go that's not sustainable. It's minus .3 percent.

So again, the classifications of your expenses and your income really need to follow generally accepted accounting principles to get a comparable and sustainable read on what's going on.

There are other issues around 990s that are important to appreciate. One is that they don't report any faster than the Medicare Cost Report in terms of coming out. They are allowed to report five months after the close of the fiscal year and many of them request extensions and so you don't get them until eight or nine months after the fiscal year. If you're relying on GuideStar it's usually a two-year lag.

So in 2004, right now, I'm able to get most of the 2002s when I go in and look for a particular hospital. So not an improvement over the Medicare Cost Report.

In terms of reporting inconsistencies, there's a lot of variability in the completeness and the accuracy, although the GuideStar disclosure has helped enormously because now they know someone can actually get access to these things and read them. But the problem is the IRS really can't enforce any kind of reporting consistency. Their audit staff reviews .43 percent or less 1 percent of charitable 990 filings and it's pretty impossible. And they're mostly looking for whether they're compliant with charitable requirements, not whether they're financially stable or have accurately reported their income statement

and balance sheet elements.

In terms of electronic availability, the GuideStar is great but it's one by one by one, with again the 40 to 80 pages at the end of the six-page form. Those of you who have used them have probably gotten a computer headache by going through, if you don't download those onto paper.

There are some electronic datasets but they do not pick up most of the elements that you would need to do financial hospital analysis. For instance, the NCCS, the Urban Institute collects these pieces of a 990 on a gig core dataset. If you look at the balance sheet items they pick up, the only one they pick up is total assets. So you don't have any breakdown of anything that would be useful to you for doing any of those capital asset ratios or understanding investment categories.

And I guess the last part that's really critical to understand is the issue of affiliated organizations. The 990 and the Medicare Cost Reports and the audits and have this problem, except that it's easiest to figure out from an audit whose reporting and what that means, in terms of what you're seeing and what you're not seeing.

So the next chart shows you, all these entities are in one stage but it's a multi-hospital system and it's in 2002. What you see is a parent company, a system A, a corporation B, a major teaching system, and then seven more affiliates.

The Medicare Cost Report pulls out all the yellow boxes here, the hospital, two physician practice companies, and a real-estate company. The Schedule G on the Medicare Cost Report reports on all those entities.

The 990 reports on just the entity that's outlined in pink, which is just the major teaching hospital.

And the audited financial statements give you a consolidated view of all of these entities as well as consolidating breakdowns on each one. So when you want to look at financial status, it might help to know what the hospital is embedded in, how the hospital is doing on its own, and then how it's doing in the context of its larger organizational affiliations.

And the next slide gives you some sense of what that means. I did do the ratios off the audit. On the pink column the hospital only, the yellow column the single system with the Medicare Cost Reports picking up, and then the green column the consolidated health system. And what you see for our ratios, our capital access ratios, is that the hospital is actually doing quite well, a 3.2 percent operating margin, 6 percent total margin, collecting receivables fine, 195 days cash on hand, almost five times debt service coverage, six-year-old plant, pretty darned

good.

The single hospital system does less well, particularly on the operating margin, a little less cash.

But the consolidated system, when you throw in all of the entities, all the companies, all the different affiliations, the system as a whole only a .2 percent operating margin and a 2 percent total margin. And there I am happy to agree that these guys don't look good. And I wouldn't classify the consolidated as a sustainable margin over all. Although they still have pretty decent cash on hand and average age of plant.

In general when you see these complex organizations, if you have a healthy hospital, it is not uncommon for that hospital to be what we call from my MBA days the cash cow for the system where the cash is leaving the hospital and supporting all of these different entities in various ways, some of which are quite strategic and some of which I don't understand fully but perhaps someone else can figure that out.

DR. ROWE: I think the reason it's not easily understood is because you can't understand it from these numbers because there are missions beyond the bottom line, the community mission or the educational mission, which drive a lot of those other investments so that they may not look good from this point of view but it's still important to the institution or the board.

DR. KANE: And I think one of the things that you as a group may want to talk about at some point is when you're thinking about how effective is a third-party payment system, which mission are you trying to cover financially? And that's something I guess you all can work on in your spare time.

Another affiliate model that's actually a problem, from both the audit perspective and the 990 prospective and the Medicare Cost Report perspective, is what I'm going to call the foundation model. That's probably not generalizable, but this is an example of a foundation model in which both the Medicare Cost Report and the 990 are trying to give you information about the hospital entity but there's no balance sheet. It basically has most of the assets in the hospital entity are what is called intercompany receivable or something meaningless. Of this \$177 million in assets, \$105 million is a receivable. So you don't really know anything about plants or debt or any of these. There's no data because the data is all consolidated and the hospital system has not created an audited separate entity statement for any of the other entities.

So you have a foundation with \$608 million in

assets, \$350 million in investments, \$167 million in tax-exempt debt. But you can't find that from the Medicare Cost Report or the 990 because it's all up there in that foundation. What they say in hospital's 990 is we can't do it. This foundation hospital is related to other organizations, the financial statements are only available on a consolidated basis so we can't give you a balance sheet. They do give you sort of an income statement.

And that creates obviously a lot of problems because a lot of hospitals do follow this model where you can't pull it out of the embedded whole.

To summarize and maybe add a few more points, there are some benefits and there are some drawbacks to the 990. The good news is all private non-profit hospitals do seem to be reporting on the 990 forms. The bad news is publicly-owned hospitals and investor-owned hospitals do not report a form 990 because they do not fall under the charitable classification.

The balance sheet does provide some useful ratios although the bad news is you often have to use the attachments so it's labor intensive. It's not an automated type of exercise.

With some changes, which various organizations that monitor these 990s have suggested, the income statement could be made more useful.

Also very helpful, when you're looking at an audit, is to have the 990 to give you hospital level detail when you can't get it from the audit. But they're not filed electronically and the hospital entity data is not audited. This is self-reported data and it doesn't always correspond to the audit.

If one wants to do a large national sample of 990 data and to tell you what's going on with the hospital industry nationally, it requires an analyst to spend a lot of time because you don't have footnotes, you don't have the right classifications of revenues or assets, there's no cash flow statement which is one of the key measures I use for understanding financial health, and the attachments are not uniformly provided.

So again, six pages of forms, 40 pages of attachments. An analyst would need a lot of time. I've timed myself a couple times. It takes anywhere from one-and-a-half to two days to do five years off a 990, to get them standardized in any way that you think you have some idea of what's going on, although you still don't know for the income statement what's operating and what's not operating, what's restricted and unrestricted.

And you cannot do any of this as a clerk. You have to have a financial accounting background. You need

somebody who's fairly well trained to do it.

DR. MILLER: That was two days for one entity, right?

DR. KANE: One entity, yes. That was me.

DR. ROWE: And that was you.

DR. KANE: Which means when my husband does it it's three days.

[Laughter.]

DR. KANE: Findings, the 990s are a useful alternative to the Medicare Cost Report when audited financial statements are not available at the hospital entity level. It's very helpful as a supplement but it does require a lot of analytic effort and training.

The Medicare Cost Report is in electronic form, which is helpful, if they could make Schedule G a better schedule. And I think the staff will be talking about that later.

And regardless of reporting source, there really needs to be some kind of effort to decide what entities are you interested in. I think you should be interested in both the hospital and the whole and be concerned about what's going on across the hospital and it's whole and what kind of financial implications the whole has.

But the reporting for that has not really followed that. So for public policy purposes it is quite hard to get a complete picture of the hospital's financial condition.

I think at that point I should stop. Any more questions?

MR. MULLER: Thank you for that very useful presentation, Nancy, again.

I think, as you said right from the start in your first slide, the report was created for another purpose. And when you have a report created for another purpose it's very hard then to meet other objectives with it. So I think in many ways it's somewhat dispositive of how one can use this. I look forward to obviously your comments, and the staff, on how to better use the cost report.

But I think your summary pretty much started from the first slide, which said this is not what it was created for.

Thank you.

MR. HACKBARTH: Other questions, comments?

DR. WOLTER: Is there interest or is anybody looking, other than ourselves, at the 990 and suggesting that it be changed so that it would be more useful? Is the IRS looking at this at all?

DR. KANE: I think the IRS is not looking at it as a tool of financial analysis. Again, they're going back to their purposes. The Urban Institute's National Center for

Charitable statistics, NCCS, is looking at the 990. I just read something that was about five pages of suggestions, some of which would make it more useful. They do pick up on the restricted/unrestricted problems. They do pick up on the consolidation problems.

But again they are very much focused on the charitable issues. They really want more disclosure on compensation and loans to insiders. So they're never going to get, because they're looking at such a wide range of organizations, they're never probably going to get to the level that you need to get with a hospital, which is a huge entity. They're looking at these little tiny organizations, many of them, compared to hospitals.

So I don't see that upgrading to the level that someone whose organization is totally focused on a hospital would get to, like the Schedule G would be focused on hospitals, could put in requirements around the way hospitals report data and be consonant with the audit requirements. I don't think the 990 will ever achieve that level of compliance or disclosure.

DR. REISCHAUER: Nancy, I thought that was a summary of where we are and where we can't go. The fact of the matter is that there's no way on god's green earth that the IRS is going to move in a direction that would make this useful for what we want because its mission is different and is limited to that mission.

There will be electronic filing of the 990s slowly taking place. So as Nancy says, it will be easier to get the stuff off the basic form. But much of what you want is in the appendices so it's not clear at all. And that won't be electronically useful, I don't think. And to the extent that we, at the Urban Institute, do delve into this area it really is to examine the evolution of the non-profit sector broadly defined.

So I don't think there's a lot of hope in that direction either.

MR. HACKBARTH: Any others?

Scheduled next is the staff presentation and I think the general drift of the conversation here is that the 990, per se, probably is not the tool to depend on. I think Nancy mentioned, at least in passing, that another direction to go is the Schedule G in the existing cost report and improving that in certain ways. I think that's, in part, what the staff are going to discuss with us.

So I'd like to have that. I hope, Nancy, you can stay and the ensuing conversation may come back to some of issues that you've raised in your presentation.

Before you go, could I just ask you a broader question? Obviously we, in MedPAC, have focused not on the

total overall margin for providers. It's been our policy to look specifically at the Medicare margin for hospitals base our recommendations on that.

These Congressional requests are, of course, requests we need to meet but they are sort of a different thrust looking at the overall financial performance of hospitals.

Looking however at the Medicare-only financial status of hospitals, what we have seen recently is declining Medicare margins for hospitals. And when we do that calculation, incidentally, we look not just at the inpatient but also if the hospital has outpatient department, home health, SNF. We look at all of them aggregated.

And when we get back in the fall to looking at Medicare financial performance of hospitals and moving towards an update recommendation again frankly, I'm a little concerned about what we're going to find given the recent trend of significantly declining Medicare margins.

You're looking at the hospital sector from a very different vantage point, looking more at the overall financial performance of hospitals. I'd be interested just in hearing your impressions of what's happening, the financial status of hospitals overall based on the work that you do?

DR. KANE: Well, as you know, I don't have a national sample. I do look at different states, often the whole state, but they're not representative. And I do look at some of the indices that are in the public domain such as the hospital almanac and some of the data that's out there.

And I think hospitals, which you see often is a peak going up to around 1997 and then they start to come down to around 2000, and then they start to move back up again. That really goes along with perhaps it's the third-party payment system paying better as the premiums have been allowed to rise.

But that's very general. There are big winners and there are big losers still out there. So as an industry it's got a huge range in performance.

So I think generalizing about the industry is very hard. Some of the bigger, wealthier, competitively advantaged organizations are doing very well, particularly if they have basically a monopoly stranglehold on a market. Whereas some of the smaller hospitals, maybe number two or three or four in the marketplace, don't do so well, often again related to the negotiation process in the private sector.

So Medicare is not the only driver, obviously. So I think it's very hard to generalize. I'd say they're doing better as a whole because of the pulling away of some of the

constraints on the private sector.

AGENDA ITEM:

Sources of financial data on Medicare providers --
mandated reports

-- Data needs and sources

-- Craig Lisk, David Glass, Jeff Stensland

MR. GLASS: Good morning. This one is the second of the two reports Craig referred to. We call it the data needs report is the short title for this.

In Section 735 of the MMA, Congress required that MedPAC report, as the slide shows, on sources of current data to determine solvency and financial circumstances of Medicare providers. Not just hospitals, other Medicare providers as well. And although we're talking about Medicare providers, as Glenn pointed out, this is talking about total financial performance and it's all payers and all costs. It shouldn't be confused with what we generally look at, which is financial performance under Medicare, whether Medicare payments cover the cost of an efficient provider.

So this is looking at a different question and this is what Congress wanted us to look at.

Nancy Kane's discussion just reflected the benefits and costs of using the IRS form 990 as a possible source of data and we're now going to discuss some other sources of data and some measures you might want to use of financial performance that might be useful for assessing financial circumstances, as they asked us.

Both reports are due June first of this year which is a little over a month.

The key questions we're going to talk about in this briefing are first, what measures used as indicators of their profitability and solvency. Jeff's going to talk about that. And then Craig is going to talk about what sources of data can be used to construct the measures and how we can improve our data sources. And then I'll sum up when we get to the end.

DR. STENSLAND: To evaluate the total profitability and solvency of providers we've convened two expert panels. The first was a panel of analysts from government. The second was a panel of private sector and academic experts in financial analysis.

The two panels thought that a provider's total profit margin is a useful indicator of total financial performance. But as Nancy Kane discussed earlier, the total margins can be dominated by non-operating losses such as investment gains. And so to avoid this problem some analysts focus on operating margins. However, our panel believes that operating margins can be inconsistent due to the inconsistency in distinguishing between operating and non-operating expenses.

Due to this inconsistency of reporting the operating margins, the panel suggested focusing on total margins in conjunction with the cash flow measure when calculating margins

for a large number of providers. Both the total margin and a cash flow measure, such as free cash flow from operations, reflect the return to the owners of the health care facility.

The panel also discussed looking at the total return to all investors in the facility. So if we wanted to look at the investment return to both stockholders and bondholders, we may look at the return on investment which is the average return to those two types of investors and is an indicator of the overall attractiveness of the industry to private investors.

So far on the first slide I talk a little bit about profitability. Now if we switch to looking at solvency, some panels suggested we examine a cash flow measure called EBITDAR, which is earnings before interest, taxes, depreciation, amortization and rent. A provider might be moving toward bankruptcy when its cash flow as measured by EBITDAR is lowered that its required debt service payments.

However, I want to stress that bankruptcy does not always lead to closure. For example, as we remember from a few years ago, a large number of SNFs filed bankruptcy. Following that they restructured their debt and they continued to service patients.

While providers with a low but positive EBITDAR may be able to restructure their debts, it will be very difficult for a provider with negative EBITDAR to restructure its debts. These providers with negative EBITDAR are not generating cash flow that can be used to pay their interest and rent expenses. So these negative EBITDAR providers, we expect them to move toward closure unless they can obtain transfers from related entities.

The transfers may come from related entities such as foundations or parent corporations. As Nancy Kane discussed, these transfers are often not reported on the income statement. And they are not included when computing the profit margins.

They are reported on the statement of changes in net assets. Therefore, when evaluating solvency it's important to examine both the changes in net assets and to calculate a cash flow measure such as EBITDAR using a cash flow statement.

So far I've talked about measures of profitability and we discussed measures of cash flow relative to debt service requirements. But when evaluating solvency, analysts also calculate days cash on hand which is a measure of the size of the provider's cash reserves. In addition, analysts often examine financial leverage on the balance sheet using measures such as the debt-to-asset ratio.

To calculate the measures of profitability and solvency discussed above, analysts would need to obtain the following four standard types of financial statements: an income statement, a cash flow statement, changes in net asset and a balance sheet. Now Craig can discuss with you how we can obtain this information in a timely and accurate fashion.

MR. LISK: We will now review five possible sources of data to create the measures that Jeff and Nancy described.

We've already discussed the IRS form 990 so I won't go into that because we've discuss the pros and cons of use of that form.

Audited financial statements are another source of data that Nancy discussed and they are prepared by independent auditing firms according to generally accepted accounting principles. They include all the forms that Jeff just mentioned and are available for providers with publicly traded bonds and for providers in some states where states require the filing of these, at least for hospitals and some other providers.

They are, however, not compiled on an organized and consistent database that may reflect the consolidated entity and they may reflect the consolidated entity and not the specific provider, although again from looking at those forms you can potentially get a lot of the information on the individual providers within the statements.

SEC form 10-Ks are a type of audited financial statement filed with the SEC by publicly traded for-profit corporations. They reflect the corporate entity and not the individual provider. Thus SEC 10-Ks are filed for, let's say HCR Manor Care Nursing Home, Gentiva Corporations but not the individual hospital, SNF, home health agency or dialysis facility.

Surveys are another source of data that can be used. The AHA annual survey provides data on the hospitals but is no more timely than the Medicare Cost Reports. It does contain some other type of information on total performance but some of that information is not publicly available. It's only available to the AHA members.

The NHIS, National Hospital Indicator Survey, is something that we have used that provides quarterly data on hospitals' total financial performance in terms of limited data in terms of total revenues and total expenses. But only for a sample of hospitals, not for other providers. And it can't be used for judging performance of an individual provider. It's only for the industry as a whole. Medicare Cost Reports is what we come down to next, which cover all Medicare providers of services. It's an electronic database. It includes not just data on Medicare cost and payments but the schedule G, as we've talked about. And all providers who file cost reports have this Schedule G. Now, it may not be identified as Schedule G for home health, for instance, but they do file a similar thing to what hospital's file what's called Schedule G. So we're going to refer it as Schedule G here.

So this contains data on a provider's total all payer operations.

Since the cost reports are one source of data filed by all providers and available electronically, it's worth spending a little time discussing some of the data issues on the cost reports and in particular Schedule G. These include the timeliness and accuracy of the information included, the consistency in the reporting entity that's included on the provider, and the completeness of the data. In other words, do the cost reports contain all the information needed to conduct a thorough financial analysis. Nancy Kane has covered a lot of that issue in her discussion, as well.

Let's move to timeliness. This chart shows the most common cost reporting periods for hospitals. This coming October fiscal

year 2003 data should be available for most providers. It's important to understand some of the facts about the timing of Medicare Cost Report data.

Cost reports, at their earliest, are available seven to eight months after the end of a provider's fiscal year. Providers have five months to complete the cost reports and then electronically submit them to the fiscal intermediaries. Then the fiscal intermediaries have 30 days to approve those cost reports, make sure they have completed them properly, and then another 30 days to put the approved cost reports into the data system for transmission to CMS.

CMS then has access to the data within 24 hours at that point in time. This is the data that is used for making the cost report files the analysts use for analysis.

Now CMS can produce special runs so the data can be available more timely after this point in time. But generally, in terms of the general community, CMS produces quarterly cost report files that are available about 45 days after the close of the quarter. But data can be available a little bit more timely if special requests are made.

So what are the prospects of having 2004 data, let's say in the fall? Well providers that begin their fiscal year in July, the top line, they still have two months to file their cost report with a fiscal intermediary at that point in time. For providers who file their cost report periods beginning in October, their fiscal year just ended so there's not likely going to be any data for them in terms of speeding up the process. And for providers who file their cost reports in January, they are still in their fiscal year.

So in terms of the timing, that's one of the problems in terms of length of the fiscal year and the length of the reporting.

The first cost report data containing substantial 2004 data, in terms of for the people who report who have July's fiscal year start dates, would generally not be available until March of 2005.

I next want to talk about the accuracy of the cost report data and there are two issues consider here. First I'm going to talk about the auditing and cost allocation. Only a small proportion of providers' cost reports are audited. While there is a statutory requirement that dialysis facilities be audited at least every three years, there is no audit requirement for other facilities. On average, about 15 percent of providers receive some form of audit every year.

The audits are also focused on items that affect payment or I should say basically only focused on items that affect payment. For hospitals, audits may focus on DSH and IME adjustments, the direct GME payments, Medicare bad debts and cost-reimbursed items like organ acquisition costs. For SNFs, audits usually focus on Medicare bad debt payments unless the audit picks up something else that they want to look at.

Items on Schedule G for the cost reports are generally not audited since they do not affect payment, although some FIs may do some checking in the desk review process to see if Schedule G

information ties to audited financial statements, there is no requirement that the FIs do so.

Now one interesting aspect in our look here is hospitals and other providers are required to submit with their cost reports a form 339 which is a survey information that's filed with the cost reports. And with that they are required to include a copy of their audited financial statements to providers to the FIs.

These audited financial statements, though, are not subject to FOIA requirements so they are not publicly available but they are used by the intermediaries for doing some checking if they find issues with the cost reports.

Hospitals and other providers that don't have audited financials for the specific provider still have to submit financial reports that are used to compile what might be the audited financial for the corporate entity because they still have those pieces that go there. So there is that information that is filed that I thought was important for you to understand that it is filed actually with the cost reports.

Cost allocation issues primarily affect the accuracy of cost estimates by department, inpatient versus outpatient for instance, or between payers, Medicare versus private payers. It does not affect the data used to examine total all-payer financial picture of the provider.

Cost allocation is an important issue for the Commission and accurately measuring Medicare cost and is the focus of another study that we are in the process of conducting, particularly for this sector costs for inpatient versus outpatient for instance.

Next there is no consistency in what providers report as a reporting entity on Schedule G of the cost report. It could be a system with affiliates, such as a hospital-owned physician practice and real estate company that Nancy had showed you. It could be just the core provider. There is no consistency in what is actually reported here.

So when we're looking at particular hospitals, we are comparing potential apples to oranges. We're not consistent here in what is gathered.

As Nancy Kane just reported to you, how the entity is defined can have substantial impact on providers' financial circumstances.

Finally, as Jeff mentioned, some of the base information required to develop some of the financial ratios Jeff and Nancy discussed are not available on Schedule G of the cost report, particularly the lack of a cash flow statement, from our panel, was considered a major shortcoming of the Schedule G of the cost reports.

Finally, I want to discuss the options for overcoming some of the limitations on Schedule G of the cost reports. To increase the timeliness of the data you could supplement with survey data, something similar to the National Hospital Indicator Survey, which has some of its own shortcomings but have similar surveys for other types of providers. Such survey data could provide more timely data on cost and revenue trends for a particular sector but cannot be used to judge what might be happening for an individual provider.

Alternatively, you could require providers to submit quarterly data on financial circumstances, something similar to the NHIS, but just as a requirement for Medicare reimbursement, for instance, data similar to what's reported on NHIS.

Another option is you could require providers to file a Schedule G separate from the cost reports, breaking it off from the cost reports because it's a separate document in some sense but it's not what the basis of the Medicare cost determinations are. And it could be separated. And our panel thought that was actually a good idea.

And it could be filed about at the same time that audited financials are required to be filed, about three months after the reporting period.

To improve the accuracy of the data, you could require random audits of providers on Schedule G data. Audits, though, could be expensive depending on the number and extent of the audits.

One of the issues you have in terms of the accuracy is providers don't have an incentive to necessarily report this data accurately since there is no checking.

So alternatively, you could have the FIs just do a check at the desk audit process for checking with consistent with the audited financials. And if providers realized that was happening, they may be more careful in what they're doing on Schedule G.

The reporting entity, including the Schedule G, is not consistent across providers and our panel thought it would be most useful to have Schedule G reflect data for basically the smallest corporate entity that contains a provider. This allows for a more apples-to-apples comparisons and gets the core facility's financial performance in terms of how, for instance, hospitals or SNFs are doing on their core business rather than what other things are happening with the other related entities, for instance.

But our expert panel also thought it was important to have what's happening with the broader organization, as well. So the consolidated reporting would also be important.

So at a minimum, a complete transaction report would be helpful to have in terms of transactions between organizations and the affiliated organizations related to the hospital and other providers or a consolidated financial statement. So essentially, two Schedule Gs in other words.

Finally, Schedule G as completed in particular does not include a cash flow statement. Our panel of experts thought that the additional of a cash flow statement would make Schedule G and the cost reports much more useful. And finally, it would be helpful though to have Schedule G also revised to use a standard financial statement form and to conform to GAAP accounting standards. It currently does not. And standardize revenue categories such as operating and non-operating revenue, which are not currently available.

So what that, I'll turn it over to David.

MR. GLASS: I will just sum it up.

Basically, what we are saying is in summary, if Congress

wants to understand the total financial performance of Medicare providers, the most direct route is probably refining Schedule G to report clearly defined complete financial information aligned with audited financials. And you could also report it separately so you could get it a little earlier.

As Ralph talked about in the last discussion, Schedule G was designed a long time ago and probably for a different purpose and it has some funny things on it like vending machine revenue and that sort of thing. It really hasn't caught up with the current state-of-the-art or generally accepted accounting principles. So it's kind of due for a redesign.

This would give us the data to compute, or give Congress the data to compute the multiple measures necessary to assess financial circumstances. These are the measures that Jeff talked about. So Congress would then want to compute those multiple measures, look at total margins, look at cash flow, look at changes in net assets. That would enable us to evaluate profitability and solvency.

And finally, we would want to look at trends over time so we can see what direction the industry is going in and to compute some of these measures as meaningful averages. For example, capital costs and investment performance. That might have a lot of year-to-year fluctuations so you'd want to look at it over several years. So if there are any questions or comments on the general organization or tenor of the report, we'd be happy to hear those.

DR. ROWE: For me, I think the question is if we had had these data before, and this updated Schedule G as you propose, looking back over the last four to five years can we identify things we would have done differently? Have we make mistakes because of the gaps and the lack of specificity in the information that would have really made a difference because changes like this are not simple and they take a while to do, et cetera, et cetera.

So are there specific years that we could say gee, you know, if we had realized this was happening in the hospital sooner we would have not done what we did or we would have done something differently? I think for Congress or somebody, that would be a question that I think would be useful to point to if there are such instances.

MR. HACKBARTH: This is where the difference between the question that Congress has asked and the one that we have focused on becomes a bit confusing and disorienting. For reasons that I've discussed ad nauseam, I believe that when making Medicare payment decisions the right thing to look at is the Medicare margin.

I don't see that as something you do by default because we don't have accurate total margin information. I think that's the right thing to do as a matter of principle. Now having said that, there are still lots of issues around timeliness of the information and the difficulty of making projections and the like.

DR. ROWE: [off microphone.] In the policy this could not be important. That's my question. Would we have done anything

different?

MR. HACKBARTH: Having said what I just said, Congress did ask for how to best get information on total margins and we're trying to answer that request.

So I don't think there's anything we would have done differently. Now whether they would've done anything differently, that's a question for Congress to answer.

DR. NEWHOUSE: I agree with this general route of bulking up Schedule G. I think, Jack, although I agree that it would be helpful to cite instances where things might have been done differently, that would be presumably pretty speculative.

I think there's a kind of legitimacy or face validity problem to just making policy with data that are a couple of years old, that just on the face of it it's better to have -- I think in the grand scheme of things this seems like reasonably small potato kinds of changes to me, that we're talking about.

I have a couple of suggestions. As I understood it, Craig, this is in respect to the timeliness. Without going to quarterly data, which I actually don't favor because I think there's more noise there because of where you recognize revenue expenses and so forth.

MR. LISK: That's a good point.

DR. NEWHOUSE: I think it's possible to analytically look at each quarter's cohort or month cohort if you want to go that far. So for example, the hospitals whose fiscal year end date is the calendar year, you analyze them. You analyze then the next quarter's cohort. You can do an analysis each quarter if you chose to. You don't have to. You can develop both a weighting factor to say how each quarter's cohort brings you up to the full sample or the universe. And you can, in principle, if you want to go back and develop an estimate of the universe, you could put together a kind of weighted average over the quarters where the weights declined as you went further back in time, reflecting the fact that those were more uncertain estimates as a predictor of the future. So that's one suggestion.

And the other suggestion is that, and I just wasn't clear on what if anything we were saying here. It may be useful, and I'll bring this up again in the specialty hospital discussion, if we had costs reported both with and without allocations. Because for some purposes one would, I think, want to know the costs of something before any allocated costs. And I don't see that that would be any great burden.

MR. LISK: There was at the panel -- I'm trying to remember the name -- it was the direct contribution margin, for instance if you're looking at a specific service, for instance, with how you would treat the allocated costs. The indirect costs would not be included in that margin estimate. So you're seeing whether the service itself is profitable or it's actual variable cost items.

DR. NEWHOUSE: Were you planning to include that as a suggestion?

MR. LISK: I guess that's a question of what we cover and going back to what we cover in terms of improvements that are for the Medicare data versus the total data. And yes, on the

Medicare data we had mentioned that's something -- and I think it's something the Commission might want to discuss about what we could be using ourselves in terms of how we could be looking at the sector margins, for instance, if we're interested in that.

DR. NEWHOUSE: I would think both we and the Congress in terms of -- I'm actually thinking of making separate update recommendations. We might want to know costs before allocations.

MR. LISK: Sure.

DR. NEWHOUSE: And then for particular policy issues like specialty hospitals one may want to know that.

MR. LISK: Yes.

MR. HACKBARTH: On the first part of it, I'm not sure I totally understand all of the timeliness suggestions that you made.

DR. NEWHOUSE: As I heard the presentation, it was kind of wait until all of the hospitals are in for that fiscal year which means that since we're reporting quarter by quarter, for the early reporters we're waiting a long time. We're way back in time for their cost reports.

I was saying at a point in time you can either look at just the cohort of the most recent reporters and try to extrapolate from there. Or what would be better would be to go back in time but down weight the further ago reporters because you're more uncertain that their picture further back is a predictor of the future.

MR. HACKBARTH: I'm not sure what the solution is our whether in fact there is a solution on the timeliness issue.

When I read the draft text, I was a little concerned that it read in a way that sort of downplayed the timeliness problem. It says one of the limitations in using cost report data is timeliness. On average cost report data are about one year in arrears.

And I understand what you mean by that, but when in fact we get to trying to make a recommendation for fiscal year 2006, we will be using fiscal year 2003 cost report data.

So it feels like a lot bigger difference than one year in arrears.

MR. LISK: That's right and that's part of the interpretation. And what you realize is at that point in time that the Commission is working, fiscal year 2004 just ended and the only cost reports really that potentially could be available are those July reporters. But because of the current timing, having five months to file, they haven't even filed their cost reports yet. And there were issues that were raised by our panel in terms of in the past, I think prior to '97, there was actually a three month requirement for filing for the cost reports. They changed it to five.

But providers were asking for and granted extensions frequently because they couldn't do it in three months. And our panel really thought that they needed the full five months to compile that information.

And there are other pieces of information that they don't necessarily get and won't have complete to having their data absolutely complete at that point in time for the Medicare part

of the cost reports.

MR. HACKBARTH: The reason I wanted to leap into the queue here is that's an issue that's come up repeatedly within the Commission. Here's a vehicle for us to, if we have any ideas, make the recommendations here. So as we go around and have our discussion, now is the time.

DR. REISCHAUER: I'd like to ask a question on this, sort of a modification of what Joe is suggesting.

What we should be interested in is the change from one year to the next. And presumably, if you did this quarterly the sample of hospitals that report at the end of July or the end of June fiscal year is the same from year-to-year. And if we look at the changes, in a sense quarter to quarter -- not it's year over year but you're sort of one group here and then the next it's another group.

If there were big trends going on, you would be picking them up and it would be, in a sense, equivalent to contemporaneous -- as contemporaneous as you could get.

MR. SMITH: I have no reason to think there's any systematic distribution. We'd have to check and make sure.

MR. MULLER: That's what I'm saying, we can certainly look at this idea.

DR. NEWHOUSE: There are actually some differences in what the hospitals are reporting but they're stable. You can adjust for that.

DR. REISCHAUER: And if you weren't looking at levels but percentage of changes...

MR. GLASS: So as I understand what you want us to do is check each of these courts, not a sample of them but everyone reporting at the end of that cohort, and do those.

MS. ROSENBLATT: It was my turn. I'm going to jump into this because I come down much harder. As somebody that spends most of my work life working on financials for the health plan industry, quarterly filings to the SEC, I just don't get this. This makes no sense to me.

Medicare is spending what, \$400 billion a year on hospital payments or something like this? I would require quarterly data submission. I would require it within 45 days of the end of the quarter. I would tie reimbursement to it. You don't submit within 45 days, you don't get paid. Or late charges or whatever. But I agree with David. Changes are long overdue. This is insanity.

And I agree with a lot of your what I would call lower-level recommendations. I would add the cash flow. I would add standard formats. I would add consolidation rules. I would require conformity with GAAP. I would create standards for what is operating and what is non-operating. And I would just try to totally reform these things and get to financial soundness.

As a country, we are focused right now on financial soundness. We have, for the last two years, seen scandal after scandal. It's time to totally change this thing.

[Applause.]

DR. ROWE: Let me make a comment relevant to what Alice said. Our company is maybe not as big as Alice's company, but

it's a big company.

[Laughter.]

DR. ROWE: We close our quarter and I certify to the SEC, under oath I think, within 10 working days of the end of the quarter. And we sign those things and certify.

And so five months, and we need an extension, is just...

DR. REISCHAUER: But you guys are big for-profit entities that are doing this anyway for market purposes. What about the 40-bed hospital in Montana?

DR. ROWE: Of it's only 40 beds it shouldn't take that long.

[Laughter.]

MR. MULLER: We might even get paid by that time.

DR. ROWE: They should be done in three or four days.

DR. STENSLAND: Maybe a question of clarification from Alice of what you're looking for.

There's two bits of financial information and it gets confusing sometimes. The one is the information on total financial performance, and that's like the Schedule G information. And these hospitals are generating that already. That's the kind that you're going to see on the SEC form 10-Ks or 10-Qs.

But then there's also the cost reporting information which is what we generate the Medicare margins off of. And they aren't doing that on a quarterly basis. So then we would have to require them to do some sort of quarterly cost accounting if we wanted the cost accounting data and a Medicare margin. If we just wanted a total margin, it's much easier because we can just say give us what you already have.

MS. ROSENBLATT: But the total margin for SEC is only the for-profits, right? All you have are these 990 things that, from Nancy's thing, aren't very good. So you need something like an SEC on a quarterly basis.

But I go along with Medicare is paying a lot of money. So I would require quarterly reporting so that Medicare has the tools that it needs to do its monitoring.

I would actually require both, but as a stopgap measure at least Medicare, as this is huge payer, should require some kind of reporting on a quarterly basis. And at a minimum within 45 days. Because I agree with Jack. We're doing it a lot sooner than that and it's possible.

Even the 40-bed hospital probably has one or two PCs and it can be done.

MS. BURKE: I think back to your original question, Glenn, and that is that we have -- at least as long as I've been involved in the discussions here at the Commission, but for years even at the committee level, there has been a hue and cry about how antiquated the date is upon which we make decisions, which is Glenn's point.

And that is there is a sense of being unable to be equitable or make wise decisions because we don't have the data in front of us. And each year the staff struggles to try and accomplish what cannot be done because the data is literally not there.

I think Alice's point is exactly right, as is Jack's. And that is I think there is an accounting that has to be done

finally. And that is that to the extent that we want this system to in fact be fair and be viewed as fair and be viewed as being based on wise decisions, we have to begin to get that data.

And a quarterly requirement for the information, in both cases, I think is not an unreasonable thing to request.

Now that also recognizes that the systems are antiquated and many of the issues that have existed in the past have been as a result of the government and what it has asked for and how it's asked for it and how it changes its rules along the road.

But I think there ought to be an agreed-upon set of minimum criteria. I think the standardization issue is also a critical one, so that we can in fact begin to see this information in a way that is understandable, irrespective of how the organization is organized and can be compared unit to unit.

So I have to say I absolutely agree. I think we've gone beyond the point where we can argue going forward that we can begin to answer what are increasingly complicated questions without having this information.

And irrespective of the size of the organization, whether it's a home health organization or a SNF or a 40-bed hospital or a 20-bed hospital, we have to expect these people to be accountable. And that data is the only thing that's going to hold them accountable. So I think we have to get there.

MR. MULLER: I think all of us, over the years, have expressed a desire for more timely data in terms of making the right policy decisions. I think it's also important to not so quickly go from thinking that the Medicare Cost Report is that easy to file compared to the standard financial statements. Most entities do have their financial statements available on a monthly basis within several weeks. That's different than filing a Medicare Cost Report. So I think Alice's enthusiasm, in one way, I'm sure a lot of entities could file their standard financial reports quite timely. That's different from filing the Medicare Cost Reports and all of the kind of changes that that requires.

So I think the theme here of how we revise the Medicare Cost Report is a very important theme for us to be pursuing. And I think the kind of discussion we've had today is in the right direction.

But if you just basically want everybody to file the financial report that they file for their own purposes, whether it's hospitals -- most people are talking about hospitals today -- but whether it's hospices or imaging centers and so forth, I think the reality is that people do have financial reports that come out much more timely than five months after a year. I mean, people do file monthly reports.

So I think we should decide do we want those kind of reports? Do we want them on a sampling basis, and so forth, compared to filling out the Medicare Cost Report? There's obviously a lot of desire to have standard information that one can compare. And whether one can truly file a Medicare Cost Report within five days after the end of quarter, I think is something I'd like to have the panel speak to, because you, in fact, did talk to experts in the field. That's point one. So I

don't think it's an exact comparison, Alice, to say that these providers don't have financial reports. They may not have the Medicare Cost Report available that quickly.

A second point, we've had a lot discussion today -- and this may be more appropriately focused to Nancy than to this panel, but I'll throw it to you.

We've had a lot of conversation today about how one treats income, especially investment income, in these reports. I'd like to ask a little bit about how we treat costs, because one of the ongoing themes is whether there are costs that are not allowable and to what extent there's a systemic bias in the reporting of costs that understates cost or overstates cost.

So whether Nancy or anybody else wants to speak to that, you've given us some of your considerations on how to think about the reporting of income. But I'd like to get a sense from you whether there's any kind of systemic under reporting of costs that also could go back to Jack's question that might have changed how we analyze some of these kind of issues.

Maybe I'll ask for some comments on the second question first, about how report costs and how we understand them. And then perhaps if you help us understand the difference between the -- and to go back to the kind of fervor we have for quick reporting -- what's the fastest one really could file a cost report if it were more simplified? That would be my second question.

DR. KANE: Medicare Cost Reporting is not my expertise. Years ago I did actually have to do desk audits of cost reports at the state level and I do know they can get pretty byzantine and I think there is some issue when you're trying to allocate costs by payer that there is a lot of issues that create bias one way or the other.

I used to teach students how to do that to maximize revenue, just to help them understand the payment system.

So there's no question, as you try to take the cost of the whole operating entity and divvy it up, artificially somewhat, into payers or even product lines, there is some biases that get introduced depending on the incentives and who's going to use the data. So there are biases.

Now when you're looking at financial statements there's less opportunity to under- or over-report, although where you classified it on the statement there is some opportunity, non-operating versus operating

So I would say on a cost report there are issues of bias and I think everybody has known about them for years, in terms of how you allocate them across product lines or payers. But I think in the financial statements it's not as much of a problem.

MR. LISK: To the second question, on the timing, in terms of our panel discussion. Some of those who are actually filing cost reports really said that they thought they needed the full five months to have everything that they needed. So of it was information that they needed. That's on the Medicare reporting in terms of the current structure of the cost reports.

In terms of other ideas, in terms of reform of the cost reports, in terms of potentially simplifying, you potentially

then get issues if you're trying to get more accurate estimates of costs in terms of dealing with cost allocation issues. You potentially make it less accurate when you do some of those simplifications, for instance. So that tends to go the other direction, potentially requiring more time.

They did, though, feel that the Schedule G type of information could be reported earlier and separated from the cost reports and thought, in fact, that it probably should be separated. So that type of total financial performance information could be -- and we said one of the options was some sort of mandated correlated report like we have for NHIS or something like that. It could be much more complete, in terms of ideas. We haven't scoped that out. But those are the types of ideas that could be pursued if you wanted to get more timely data.

Now more timely data like that, depending upon what information is collected, could get you not necessarily on Medicare but could get you what the current trends are in changes in costs per case or costs per some unit of service, for instance, that we currently just rely on from NHIS, for instance, potentially is some indicator that we sometimes use.

But that data has some serious limitations because of the sample size and other things like that. So a broader reporting would potentially be beneficial. We know providers can do it. There is reporting into Databank for some of this information that many states require.

MR. MULLER: There's obviously an enormous difference, like a 14 month difference between five months after end of a fiscal year and 10 months after a quarter. So we are talking such different time frames that I'd like to reconcile kind of our fervor for getting it 10 days after a quarter end and then your sense of -- now I understand the difference you're drawing between the Schedule G and the cost report. But that seems to be such an enormous difference in time, 14 months, that it would be useful for us to speak to what can be done on a more timely basis.

And if it's Schedule G, we should perhaps make some estimates as to what a reasonable amount of time is to be able to secure that on a sample that's sufficient to be able to make any kind of policy judgments of it.

MR. HACKBARTH: We're already overtime substantially and since this is Friday I fear we're getting to the point if we run over time we're going to start losing people for our final segment.

I do want to give Nick and Pete the opportunity to come or ask questions, they've been in line for quite a while. But then we're going to have to cut it off and move forward.

DR. WOLTER: I would share Alice's enthusiasm for moving ahead. I think it is disconcerting that with the level of expenditure that we don't tighten up reporting.

I am still, though, a little bit kicking around whether quarterly makes a lot of sense in this sector. There really are other reasons for it in the publicly traded sector. So that might be one that we need to think through. But certainly an

annual reporting that is linked back to audited statements makes it off a lot of sense, and revising Schedule G makes a lot of sense to me.

I would hope that would be done along the lines though of looking at the cost report for other areas that might be simplified in addition to just adding new requirements. Because I think that cost report does need a look and it needs some changes.

On a more specific issue, I would hope we would look at reporting of both operating and non-operating margins because although there is variability in how organizations put things into the operating side, for example, that is tightening up over time. And I think they tell us each something that is useful. And then maybe over time it becomes more consistent.

And as Glenn pointed out, we have kind of gotten into two sets of issues in this conversation. One is Congress's desire to understand overall financial health in the health care sector.

The second is what's going to help us? Whether it's quarterly or annual reporting of this data, that still doesn't get us to some of the issues we're facing in terms of how is Medicare covering costs, particularly in the individual sector areas like inpatient versus outpatient. And I think we still have some very significant issues there.

I certainly agree with our chapter that overall Medicare margin is something that we should really use as our linchpin.

But underneath that, we're still struggling with systems of payment that are different for inpatient and outpatient. And as we do updates, it's very, very hard to know how to update those separately. And I think that then leads to providers having different incentives in those sectors in terms of how they do their business planning.

Those issues are not solved by whatever direction we take on this particular data reporting.

MR. DeBUSK: Of course, for the last four years I guess I've been most vocal about old data and I totally agree with Alice and Sheila.

But you know, the whole cost reporting system came out of a time where we were on a cost-plus basis, the old TEFRA system. Perhaps we should look at it in a different way. Maybe we should take the GAAP system and look at modifying what is needed on the cost report for Medicare to the GAAP system and try to standardize some of this. Because it's everywhere.

We need to break the old plate and start over.

MR. HACKBARTH: Okay. I know there's more that could be said but I'm afraid we really do need to move on.